		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043943

Facility Name: TERRACE NURSING HOME

Address: 1615 SUNSET AVE. (Number) WAUKEGAN (City) 60087 (Zip Code)

County: LAKE

Telephone Number: (847) 244-6700 **Fax #** (847) 244-7925

IDPA ID Number: 36-4228300

Date of Initial License for Current Owners: 07/01/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	65	Skilled (SNF)	65	23,725	1
2		Skilled Pediatric (SNF/PED)			2
3	50	Intermediate (ICF)	50	18,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	115	41,975	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	4,092	2,295	3,940	10,327	8
9	SNF/PED					9
10	ICF	15,928	11,891	215	28,034	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	20,020	14,186	4,155	38,361	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.39%

D. How many bed-hold days during this year were paid by Public Aid?
312 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 07/01/98

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 07/01/98 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 22 and days of care provided 3,908

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	161,623	10,968	8,052	180,643		180,643	0	180,643			1
2	Food Purchase		151,365		151,365		151,365	(1,114)	150,251			2
3	Housekeeping	155,645	15,898	0	171,543		171,543	0	171,543			3
4	Laundry	65,362	15,024	6,344	86,730		86,730	0	86,730			4
5	Heat and Other Utilities			88,243	88,243		88,243	289	88,532			5
6	Maintenance	74,126	14,245	22,933	111,304		111,304	880	112,184			6
7	Other (specify):*			14,055	14,055		14,055	82	14,137			7
8	**TOTAL General Services**	456,756	207,500	139,627	803,883	0	803,883	137	804,020			8
	B. Health Care and Programs											
9	Medical Director	0		9,960	9,960		9,960	0	9,960			9
10	Nursing and Medical Records	1,772,331	67,901	8,911	1,849,143		1,849,143	0	1,849,143			10
10a	Therapy	45,690		0	45,690		45,690	0	45,690			10a
11	Activities	49,156	5,524	2,816	57,496		57,496	0	57,496			11
12	Social Services	31,728		4,257	35,985		35,985	0	35,985			12
13	Nurse Aide Training			6,300	6,300		6,300	0	6,300			13
14	Program Transportation			12,849	12,849		12,849	0	12,849			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,898,905	73,425	45,093	2,017,423	0	2,017,423	0	2,017,423			16
	C. General Administration											
17	Administrative	73,341		112,500	185,841		185,841	(100,989)	84,852			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			41,648	41,648		41,648	7,100	48,748			19
20	Dues, Fees, Subscriptions & Promotions			24,439	24,439		24,439	(10,548)	13,891			20
21	Clerical & General Office Expenses	101,655	16,453	81,333	199,441		199,441	(22,202)	177,239			21
22	Employee Benefits & Payroll Taxes			395,978	395,978		395,978	0	395,978			22
23	Inservice Training & Education			1,151	1,151		1,151	68	1,219			23
24	Travel and Seminar			0	0		0	0	0			24
25	Other Admin. Staff Transportation			34,225	34,225		34,225	478	34,703			25
26	Insurance-Prop.Liab.Malpractice			69,252	69,252		69,252	2,466	71,718			26
27	Other (specify):*			87,728	87,728		87,728	(81,129)	6,599			27
28	**TOTAL General Administration**	174,996	16,453	848,254	1,039,703	0	1,039,703	(204,756)	834,947			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,530,657	297,378	1,032,974	3,861,009	0	3,861,009	(204,619)	3,656,390			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number TERRACE NURSING HOME #0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			89,045	89,045		89,045	(1,569)	87,476			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			14,938	14,938		14,938	228,518	243,456			32
33	Real Estate Taxes			53,644	53,644		53,644	654	54,298			33
34	Rent-Facility & Grounds			431,216	431,216		431,216	(431,216)	0			34
35	Rent-Equipment & Vehicles			26,996	26,996		26,996	(5,349)	21,647			35
36	Other (specify):*				0		0	24,339	24,339			36
37	**TOTAL Ownership**			615,839	615,839	0	615,839	(184,623)	431,216			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		89,562	165,297	254,859		254,859	0	254,859			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			62,963	62,963		62,963	0	62,963			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	89,562	228,260	317,822	0	317,822	0	317,822			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,530,657	386,940	1,877,073	4,794,670	0	4,794,670	(389,242)	4,405,428			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(56,565)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,114)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(1,047)	20		17
18	Fines and Penalties	(87)	21		18
19	Entertainment	0	20		19
20	Contributions	(1,968)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(87,728)	27		24
25	Fund Raising, Advertising and Promotional	(5,282)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,790)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(1,491)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (158,072)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(231,170)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (231,170)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (389,242)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

TERRACE NURSING HOME

ID# 0043943

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -1491	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(1,491)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TERRACE NURSING HOME # 0043943 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,114)	0	0	0	0	0	0	0	0	0	0	(1,114)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	289	0	0	0	0	0	0	0	289	5
6	Maintenance	(1,491)	0	1,564	807	0	0	0	0	0	0	0	880	6
7	Other (specify):*	0	0	82	0	0	0	0	0	0	0	0	82	7
8	**TOTAL General Services**	(2,605)	0	1,646	1,096	0	0	0	0	0	0	0	137	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(100,989)	0	0	0	0	0	0	0	0	0	(100,989)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	339	6,693	68	0	0	0	0	0	0	0	7,100	19
20	Fees, Subscriptions & Promotions	(11,087)	0	539	0	0	0	0	0	0	0	0	(10,548)	20
21	Clerical & General Office Expenses	(87)	5,252	(27,655)	288	0	0	0	0	0	0	0	(22,202)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	68	0	0	0	0	0	0	0	0	68	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	359	119	0	0	0	0	0	0	0	0	478	25
26	Insurance-Prop.Liab.Malpractice	0	614	1,778	74	0	0	0	0	0	0	0	2,466	26
27	Other (specify):*	(87,728)	2,203	4,396	0	0	0	0	0	0	0	0	(81,129)	27
28	**TOTAL General Administration**	(98,902)	(92,222)	(14,062)	430	0	0	0	0	0	0	0	(204,756)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(101,507)	(92,222)	(12,416)	1,526	0	0	0	0	0	0	0	(204,619)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TERRACE NURSING HOME # 0043943 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(56,565)	235	301	688	53,772	0	0	0	0	0	0	(1,569)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	329	1,036	227,153	0	0	0	0	0	0	228,518	32
33	Real Estate Taxes	0	0	0	654	0	0	0	0	0	0	0	654	33
34	Rent-Facility & Grounds	0	0	0	0	(431,216)	0	0	0	0	0	0	(431,216)	34
35	Rent-Equipment & Vehicles	0	1,031	2,020	(8,400)	0	0	0	0	0	0	0	(5,349)	35
36	Other (specify):*	0	0	0	0	24,339	0	0	0	0	0	0	24,339	36
37	**TOTAL Ownership**	(56,565)	1,266	2,650	(6,022)	(125,952)	0	0	0	0	0	0	(184,623)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(158,072)	(90,956)	(9,766)	(4,496)	(125,952)	0	0	0	0	0	0	(389,242)	45

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MORRIS ESFORMES	50	SEE LIST ATTACHED		EMI ENTERPRISES	LINCOLNWOOD	CONSULTING
PHILIP ESFORMES	50			EKS MANAGEMENT	LINCOLNWOOD	BOOKKEEPING
				EKS MANAGEMENT	LINCOLNWOOD	HOME OFFICE
						RENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	MANAGEMENT FEE	$ 112,500	EMI ENTERPRISES		$	$ (112,500)	1
2	V		17	OFFICERS SALARY				11,511	11,511	2
3	V		19	ACCOUNTING FEES				339	339	3
4	V		21	TOTAL OFFICE				5,252	5,252	4
5	V		25	TRANSPORTATION				359	359	5
6	V		26	INSURANCE				614	614	6
7	V		27	EMPLOYEE BENEFITS				2,203	2,203	7
8	V		30	DEPRECIATION (SL)				235	235	8
9	V		35	AUTO LEASE				1,031	1,031	9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 112,500			$ 21,544	$ * (90,956)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	OUTSIDE CLERICAL	$ 53,820	EKS MANAGEMENT, INC		$	$ (53,820)	15
16	V	6	PAINTING / DECORATING				1,564	1,564	16
17	V	7	SCAVENGER				82	82	17
18	V	19	PROFESSIONAL FEES				6,693	6,693	18
19	V	20	WANT ADS				539	539	19
20	V	21	TOTAL OFFICE				26,165	26,165	20
21	V	23	SEMINARS				68	68	21
22	V	25	TRANSPORTATION				119	119	22
23	V	26	INSURANCE				1,778	1,778	23
24	V	27	EMPLOYEE BENEFITS				4,396	4,396	24
25	V	30	DEPRECIATION (SL)				301	301	25
26	V	32	INTEREST-INSURANCE FINANCE				329	329	26
27	V	35	EQUIPMENT RENT				2,020	2,020	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 53,820			$ 44,054	$ * (9,766)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	OFFICE RENT	$ 8,400	IME REALTY CORP		$	$ (8,400)	15
16	V	5	UTILITIES				289	289	16
17	V	6	REPAIRS & MAINTENANCE				807	807	17
18	V	19	PROFESSIONAL FEES				68	68	18
19	V	21	OFFICE EXPENSE				288	288	19
20	V	26	INSURANCE				74	74	20
21	V	30	DEPRECIATION (SL)				688	688	21
22	V	32	INTEREST				1,036	1,036	22
23	V	33	REAL ESTATE TAX				654	654	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 8,400			$ 3,904	$ * (4,496)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 431,216	THE TERRACE INVESTOR GROUP	100.00%	$	$ (431,216)	15
16	V	30	DEPRECIATION - BUILDING				53,772	53,772	16
17	V	32	MORTGAGE INTEREST				227,153	227,153	17
18	V	36	AMORTIZATION OF LOAN COST				24,339	24,339	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 431,216			$ 305,264	$ * (125,952)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	GEN. PARTNER	ADMINISTRATIVE		SEE ATTACHED			SALARY	$	17-8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES, INC.
Street Address: 3737 W. ARTHUR AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	616,513	11	$ 185,000	$ 185,000	38,361	$ 11,511	1
2	19	ACCOUNTING FEES	PATIENT DAYS	616,513	11	5,451		38,361	339	2
3	21	TOTAL OFFICE	PATIENT DAYS	616,513	11	84,399	60,672	38,361	5,252	3
4	25	TRANSPORTATION	PATIENT DAYS	616,513	11	5,763		38,361	359	4
5	26	INSURANCE	PATIENT DAYS	616,513	11	9,863		38,361	614	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	616,513	11	35,399		38,361	2,203	6
7	30	DEPRECIATION	PATIENT DAYS	616,513	11	3,788		38,361	235	7
8	35	AUTO LEASE	PATIENT DAYS	616,513	11	16,569		38,361	1,031	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 346,232	$ 245,672		$ 21,544	25

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT, INC
Street Address: 3737 W. ARTHUR AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTING / DECORATING	PATIENT DAYS	616,513	11	$ 25,141	$	38,361	$ 1,564	1
2	7	SCAVENGER	PATIENT DAYS	616,513	11	1,310		38,361	82	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	616,513	11	107,563	91,129	38,361	6,693	3
4	20	WANT ADS	PATIENT DAYS	616,513	11	8,660		38,361	539	4
5	21	TOTAL OFFICE	PATIENT DAYS	616,513	11	420,511	316,407	38,361	26,165	5
6	23	SEMINARS	PATIENT DAYS	616,513	11	1,100		38,361	68	6
7	25	TRANSPORTATION	PATIENT DAYS	616,513	11	1,912		38,361	119	7
8	26	INSURANCE	PATIENT DAYS	616,513	11	28,579		38,361	1,778	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	616,513	11	70,657		38,361	4,396	9
10	30	DEPRECIATION	PATIENT DAYS	616,513	11	4,837		38,361	301	10
11	32	INTEREST - INS. FINANCING	PATIENT DAYS	616,513	11	5,286		38,361	329	11
12	35	EQUIPMENT RENT	PATIENT DAYS	616,513	11	32,463		38,361	2,020	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 708,019	$ 407,536		$ 44,054	25

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP
Street Address: 3737 W. ARTHUR AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	203,249	11	$ 6,990	$	8,400	$ 289	1
2	6	REPAIRS / MAINTENANCE	INCOME	203,249	11	19,525		8,400	807	2
3	19	PROFESSIONAL FEES	INCOME	203,249	11	1,650		8,400	68	3
4	21	OFFICE EXPENSE	INCOME	203,249	11	6,958		8,400	288	4
5	26	INSURANCE	INCOME	203,249	11	1,798		8,400	74	5
6	30	DEPRECIATION	INCOME	203,249	11	16,647		8,400	688	6
7	32	INTEREST	INCOME	203,249	11	25,074		8,400	1,036	7
8	33	REAL ESTATE TAX	INCOME	203,249	11	15,815		8,400	654	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 94,457	$		$ 3,904	25

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: THE TERRACE INVESTOR GROUP
Street Address: 3737 W. ARTHUR AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION - BUILDING	DIRECT COST	1	1	$ 53,772	$	1	$ 53,772	1
2	32	MORTGAGE INTEREST	DIRECT COST	1	1	227,153		1	227,153	2
3	36	AMORTIZATION OF LOAN	DIRECT COST	1	1	24,339		1	24,339	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 305,264	$		$ 305,264	25

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	THE TERRACE INVESTOR GROUP						$	$			$	1
2	LASALLE BANK		X	MORTGAGE	$20,450.00	05/15/98	2,400,000	0		0.0825	93,178	2
3	LASALLE BANK		X	MORTGAGE	$25,319.00	06/29/01	3,400,000	3,382,061	06/29/06	0.0766	133,975	3
4												4
5	RELATED PARTY ALLOCATION										1,365	5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL			350,000	0			14,938	6
7												7
8												8
9	TOTAL Facility Related				$45,769.00		$ 6,150,000	$ 3,382,061			$ 243,456	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 6,150,000	$ 3,382,061			$ 243,456	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 51,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 52,622	2
3. Under or (over) accrual (line 2 minus line 1).		$ 1,022	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 52,622	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 53,644	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	47,814	8
	1997	50,402	9
	1998	51,228	10
	1999	50,736	11
	2000	52,622	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TERRACE NURSING HOME COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0043943

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-08-403-011	NURSING HOME	$ 52,621.68	$ 52,621.68
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 52,621.68	$ 52,621.68

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 42,000 B. General Construction Type: Exterior BRICK Frame MASONRY/STEEL Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 0
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 0
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		0		$	1
2					2
3	TOTALS			$ 0	3

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	112				$ 2,088,222	$ 53,772	31.5	$ 53,772	$	$ 787,019	4
5											5
6											6
7	RELATED PARTY					565		565			7
8											8
	Improvement Type**										
9	DOOR BYPASS ALARM			1998	3,453	89	39	89		271	9
10	BOILER			2000	32,900	1,197	27.5	1,197		2,244	10
11	DOORS AND FRAMES			2000	3,366	122	27.5	122		199	11
12	FIRE DOOR			2000	5,039	183	27.5	183		298	12
13	FIRE DAMPERS			2000	12,123	441	27.5	441		643	13
14	NURSING STATION			2001	15,200	299	27.5	299		299	14
15	EJECTOR PUMPS			2001	5,898	116	27.5	116		116	15
16	OVER THE BED LIGHTS			2001	6,142	121	27.5	121		121	16
17	FLOORING			2001	81,365	16,273	10	4,068	(12,205)	4,068	17
18	CUBICLE CURTAINS & BLINDS			2001	43,874	8,775	10	2,194	(6,581)	2,194	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,297,582	$ 81,953		$ 63,167	$ (18,786)	$ 797,472	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 74,998	$ 13,710	$ 11,720	$ (1,990)		$ 22,928	71
72	Current Year Purchases	238,594	47,719	11,930	(35,789)		11,930	72
73	Fully Depreciated Assets				0			73
74	IME, EKS, EMI ALLOCATION		659	659	0			74
75	TOTALS	$ 313,592	$ 62,088	$ 24,309	$ (37,779)		$ 34,858	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,611,174	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 144,041	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 87,476	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (56,565)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 832,330	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 17,669 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	DON	98 DODGE CARAVAN	$ 440.00	$ 440	17
18	NURSING, FACILITY	98 DODGE VAN	650.00	650	18
19	NURSING, FACILITY	01 CHEVY EXP. VAN	700.00	8,237	19
20					20
21	TOTAL		$ 1,790.00	$ 9,327	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[ ]
COMMUNITY COLLEGE	[X]
HOURS PER AIDE	140

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	[ ]
IN OTHER FACILITY	[ ]
HOURS PER AIDE	

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests		6,300		6,300
9	TOTALS	$ 0	$ 6,300	$ 0	$ 6,300
10	SUM OF line 9, col. 1 and 2 (e)	$ 6,300			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	10
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	0
2. From other facilities (f)	
TOTAL TRAINED	10

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 72,893	$		$ 72,893	1
2	Licensed Speech and Language Development Therapist		hrs			5,651			5,651	2
3	Licensed Recreational Therapist		hrs			80,959			80,959	3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				89,562		89,562	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): RADIOLOGY/LAB					5,794			5,794	13
14	TOTAL			$		$ 165,297	$ 89,562		$ 254,859	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 73,866	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	490,079		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	118,612		6
7	Other Prepaid Expenses	27,318		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 709,875	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	209,360		15
16	Equipment, at Historical Cost	313,592		16
17	Accumulated Depreciation (book methods)	(118,066)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): OPTION DEPOSIT	230,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 634,886	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,344,761	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,118,308	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	83,470		30
31	Accrued Taxes Payable (excluding real estate taxes)	34,206		31
32	Accrued Real Estate Taxes(Sch.IX-B)	52,622		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,288,606	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,288,606	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 56,155	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,344,761	$ 0	48

***(See instructions.)**

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 126,441	1
2	Restatements (describe):		2
3	ILLINOIS REPLACEMENT TAX	(6,907)	3
4	ROUNDING	2	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 119,536	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	184,619	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(248,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (63,381)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 56,155	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,885,787	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,885,787	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	91,010	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 91,010	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,492	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,492	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,979,289	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	803,883	31
32	Health Care	2,017,423	32
33	General Administration	1,039,703	33
	B. Capital Expense		
34	Ownership	615,839	34
	C. Ancillary Expense		
35	Special Cost Centers	254,859	35
36	Provider Participation Fee	62,963	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,794,670	40
41	**Income before Income Taxes (line 30 minus line 40)****	184,619	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 184,619	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	6,123	6,696	$ 140,941	$ 21.05	1
2	Assistant Director of Nursing					2
3	Registered Nurses	28,610	30,730	707,396	23.02	3
4	Licensed Practical Nurses	1,704	1,780	38,020	21.36	4
5	Nurse Aides & Orderlies	79,367	86,806	860,488	9.91	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,377	3,694	45,690	12.37	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,745	6,191	49,156	7.94	10
11	Social Service Workers	2,674	2,707	31,728	11.72	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	18,603	20,253	161,623	7.98	15
16	Dishwashers					16
17	Maintenance Workers	6,044	6,330	74,126	11.71	17
18	Housekeepers	18,448	20,266	155,645	7.68	18
19	Laundry	7,208	7,753	65,362	8.43	19
20	Administrator	2,080	2,227	73,341	32.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,155	12,174	101,655	8.35	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,439	1,644	25,486	15.50	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	192,577	209,251	$ 2,530,657 *	$ 12.09	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	monthly fee	$ 6,728	1-3	35
36	Medical Director	monthly fee	9,960	9-3	36
37	Medical Records Consultant	monthly fee	1,080	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly fee	6,309	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	56	2,816	11-3	44
45	Social Service Consultant	84	4,257	12-3	45
46	Other(specify)				46
47	Utililization Review Fee	monthly fee	1,080	10-3	47
48					48
49	TOTAL (lines 35 - 48)	140	$ 32,230		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	20	442		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	20	$ 442		53

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ROSE SHULTS	ADMIN	0	$ 73,341
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 73,341

B. Administrative - Other

Description		Amount
EMI	MANAGEMENT FEE	$ 112,500
TOTAL (agree to Schedule V, line 17, col. 3)		$ 112,500
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 4,332
HDSI	DATA PROCESSING	10,812
NCS	DATA PROCESSING	2,048
MAXXSOURCE	DATA PROCESSING	125
MIDAMERICA	DATA PROCESSING	1,320
KRUPNICK BOKOR	ACCOUNTING	11,100
MCBRIDE, BAKER & COLES	LEGAL	3,934
CHICAGO TITLE		815
RICKARD PEELO	MEDICARE CONSULTANT	4,125
PERSONNEL PLANNERS	UC CONSULTANT	3,037
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 41,648

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 65,406
Unemployment Compensation Insurance	13,788
FICA Taxes	193,650
Employee Health Insurance	111,519
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	1,177
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	10,438
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 395,978

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	7,020
Health Care Worker Background Check	1,320
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	8,072
TRUST FEES/CONTRIBUTION	3,015
RELATED PARTY	539
DUES & SUBSCRIPTIONS	3,514
LICENSES & PERMITS	1,098
TRUST FEES/CONTRIBUTIONS	(3,015)
Less: Public Relations Expense	(0)
Non-allowable advertising	(5,282)
Yellow page advertising	(2,790)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,891

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	7/98	$ 12,847	3 YRS	$ 2,141	$ 4,282	$ 4,282	$ 2,142	$	$	$	$	$
2	PAINT/DECORATING	7/99	3,639	3 YRS		606	1,213	1,213	607				
3	PAINT/DECORATING	7/01	5,815	3 YRS				969	1,938	1,938	970		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 22,301		$ 2,141	$ 4,888	$ 5,495	$ 4,324	$ 2,545	$ 1,938	$ 970	$	$

Facility Name & ID Number TERRACE NURSING HOME # 0043943 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $2195**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,199** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **62,963**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: TERRACE NURSING HOME **#0043943** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,728	
	REPAIRS & MAINTENANCE		1,324	
			0	8,052
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		6,344	
			0	6,344
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		32,399	
	ELECTRICITY		37,646	
	WATER		17,760	
	CABLE TV - LOBBY		438	
			0	88,243
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		1,662	
	PAINTING & DECORATING		5,815	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		6,240	
	ELEVATOR MAINTENANCE & REPAIR		3,671	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,551	
	FIRE SERVICE		3,994	
			0	
			0	
			0	22,933
7	**OTHER**			
	SCAVENGER		10,240	
	SECURITY SERVICE		3,815	14,055
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,960	9,960

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	442	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,080	
	PHARMACY CONSULTANT	XVIII B 39-2	6,309	
	UTILIZATION REVIEW FEES	XVIII B __-2	1,080	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	8,911
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,816	
			0	2,816
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	4,257	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	4,257
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	6,300	6,300

Facility Name & ID Number TERRACE NURSING HOME **#0043943** **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		12,849	12,849
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	112,500	112,500
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	18,637	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	23,011	
			0	41,648
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	5,282	
	EMPLOYEE WANT ADS	XIX F	7,020	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	3,514	
	LICENSES & PERMITS	XIX F	1,498	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	2,790	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	1,047	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,968	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,320	24,439
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		156	
	EQUIPMENT REPAIR & MAINTENANCE		4,495	
	OUTSIDE CLERICAL SERVICES		53,820	
	PENALTIES / OVERDRAFT CHARGES	VI 18	87	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		22,775	
	MESSENGER SERVICE		0	
			0	81,333

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	193,650	
	UNEMPLOYMENT COMPENSATION	XIX D	13,788	
	WORKERS COMPENSATION INSURANC	XIX D	65,406	
	HOSPITALIZATION INSURANCE	XIX D	111,519	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,177	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	10,438	
	CHICAGO HEAD TAX	XIX D	0	395,978
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,151	1,151
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		34,225	34,225
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		69,252	69,252
27	**OTHER**			
	BAD DEBTS	VI 24	87,728	
			0	87,728

GRAND TOTAL COLUMN 3 OTHER 1,032,974

TERRACE NURSING HOME
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	151,365	PATIENT MEALS	115083
LESS SALES TAX	(1,114)	ADD EMPLOYEE MEALS	0
NET FOOD	152479	TOTAL MEALS/YEAR	115083
TOTAL PATIENT CENSUS	38,361	NET FOOD	152479
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	115083
TOTAL PATIENT MEALS	115083	COST PER MEAL	1.32
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		